**Seriously Health Medical Marijuana Certification**

Patient Name: _____ DOB: _____ Date: _____

PLEASE FILL OUT THE INFORMATION BELOW TO THE BEST OF YOUR KNOWLEDGE. IF THE QUESTION DOES NOT APPLY TO YOU, LEAVE BLANK.

**MEDICAL HISTORY**

Past medical history (such as diabetes, high blood pressure, back pain, etc.)

_____
_____

Current prescription (including over the counter medications)

_____
_____

Medication Allergies:

_____
_____

Tobacco use and frequency:

_____

Alcohol use and frequency:

_____

Illicit drug use and frequency:

_____

**TREATMENT EFFECTIVENESS FOR QUALIFYING CONDITION**

Please answer the following questions on how effective your current treatment plan is for your medical condition:

_____
_____

How effective are these in your treatment? (circle one)
NOT AT ALL MILD MODERATE SIGNIFICANT

For individuals renewing their cannabis card:

How effective is medical cannabis in your treatment? (circle one)
NOT AT ALL MILD MODERATE SIGNIFICANT

Are you having any side effects from medical cannabis?

_____

_____

**I certify the above information is true and correct:**

PATIENT SIGNATURE:

_____

DATE:

_____

SERIOUSLY HEALTH LLC

I understand that the information I have been asked to provide is for the evaluation of my medical condition and to determine if it is a qualifying medical condition approved under the Virginia Medical Cannabis Program, and if I have no accurately and completely disclosed the requested information, it may adversely impact the provider's ability to diagnose my condition and/or determine whether I qualify for medical cannabis per Virginia state law.

I certify: (initial each item):

____ I certify that the information I am providing is accurate and complete and has been offered only for the purpose of determining if I have a qualifying medical condition.

____ I certify that my condition is chronic and debilitating to the quality of my life.

____ I certify that I am not seeking marijuana for illegal purposes.

I understand: (initial each item)

____ The medical provider, staff, or representatives of Seriously Health LLC are neither providing, recommending, dispensing, nor encouraging me to obtain medical marijuana.

____ The medical provider, staff, and representatives of Seriously Health LLC are addressing specific questions regarding my qualification for entry into the Virginia Medical Cannabis Program, and unless otherwise stated, are in no way establishing themselves as my medical provider beyond the requested evaluation/consultation. All patients should follow up with their primary care provider or mental health provider as appropriate.

____ Seriously Health LLC recommends that all patients follow the advice of their primary care provider and/or mental health provider as appropriate.

____ Should an approval be made for my medicinal use of cannabis, there is a renewal date specified by the state. It is my responsibility to see the medical provider to assess the possible continuance of cannabis use beyond the term of approval.

____ I acknowledge that I am a resident of Virginia, I am at least 18 years of age and have no misrepresented any information to Seriously Health LLC, or if am under 18 years of age I am the Legal Guardian of the Patient.

____ I acknowledge that I have voluntarily sought an evaluation from Seriously Health LLC and am in no way being coerced to do so.

____ I acknowledge the federal government has classified marijuana as a Schedule 1 controlled substance. Schedule 1 substances are defined, in part, as having 1. A high proential for abuse; 2. No currently accepted medical use in treatment in the United States; and 3. A lack of accepted safety for use under medical supervision. Federal law prohibits the manufacture, distribution, and possession of marijuana even in states, such as Virginia, which have modified their state laws to treat marijuana as a medicine.

Patient Signature Date

SERIOUSLY HEALTH LLC
INFORMED CONSENT AND RELEASE FROM LIABILITY

I am being evaluated for a medical provider's qualification for admission into the Virginia Medical Cannabis Program. The medical provider will make this qualification based, in part, on the medical information I have provided. I have not misrepresented my medical condition in order to obtain a qualification and it is my intent to use marijuana only as needed for the treatment of my medical condition, not for recreational or non-medical purposes. I understand that it is my responsibility to be informed regarding state and federal laws regarding the possession, use sale/purchase and/or distribution of marijuana.

I have been informed of and understand the following: (please initial each item)
_____ Marijuana has not been approved by the FDA for marketing as a drug. Therefore the "manufacture" of marijuana for medical use is not subject to any standards, quality control, or other oversight. Marijuana may contain unknown quantities of active ingredients, impurities, contaminants, and substances in addition to THC, which is the primary psychoactive chemical component of marijuana.
_____ The use of marijuana can affect coordination, motor skills, cognition, such as the ability to think, judge, and reason. While using marijuana, I should not drive, operative heavy machinery or engage in any activities that require me to be alert and/or respond quickly. I understand that if I drive while under the influence of marijuana, I can be arrested for "driving under the influence."
____ Potential SIDE EFFECTS from the use of marijuana include, but are not limited to, the following: dizziness, anxiety, confusion, cough, bronchitis, lung problems, sedation, low blood pressure, impairment of short term memory, euphoria, nausea and vomiting (hyperemesis syndrome), difficulty in completing complex tasks, suppression of the body's immune system, inability to concentrate, impaired motor skills, paranoia, psychotic symptoms, general apathy, depression and/or restlessness. Marijuana may exacerbate schizophrenia. In addition, the use of marijuana may increase eating, alter my perception of time and space and impair my judgement.
____ I understand that using marijuana while under the influence of alcohol, opioids/opiates, sedatives, or illicit drugs is not recommended. Additional side effects may become present when using both alcohol, opioids/opiates, sedatives, and illicit drugs with marijuana.
____ I agree to contact a medical provider or the emergency department if I experience any of the side effects listed above, or if I become depressed or psychotic, have suicidal thoughts, or experience crying spells. I will also contact a medical provider or the emergency department if I experience respiratory problems, changes in my normal sleeping problems, extreme fatigue, increased irritability, or begin to withdraw from my family and/or friends.
____ The risks, benefits and drug interactions of marijuana are not fully understood. If I am taking medication or undergoing treatment for any medical condition, I understand that I should consult with my primary medical or mental health provider before using marijuana and that I should not discontinue any medication or treatment previously prescribed unless advised to do so by the treating medical provider.
SIGNED: _____ DATE: _____